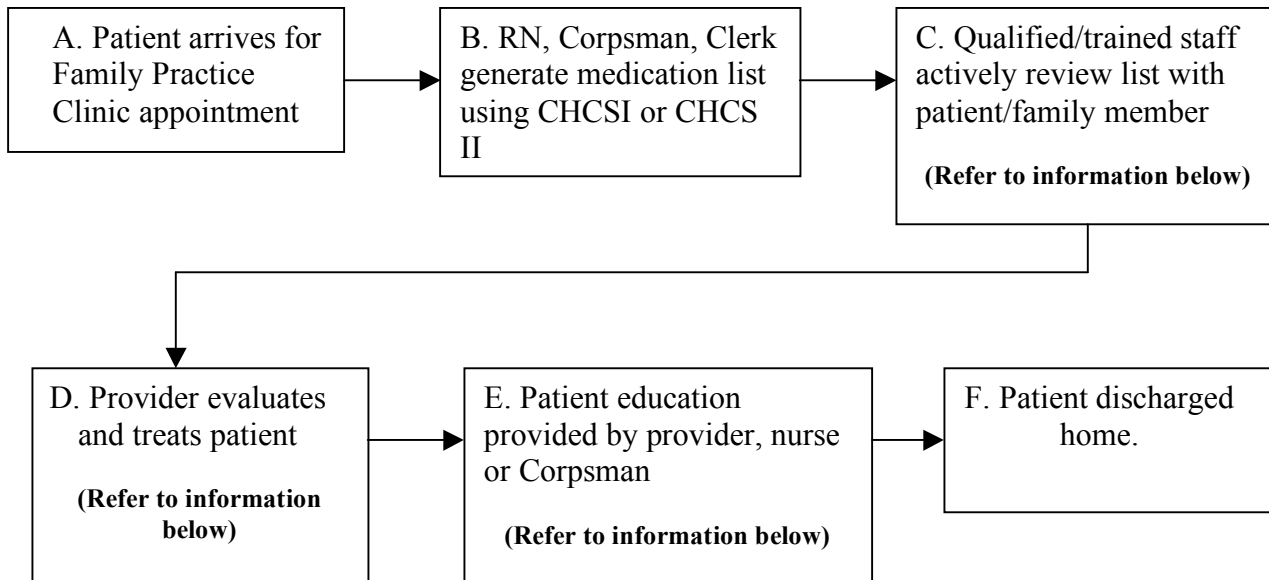


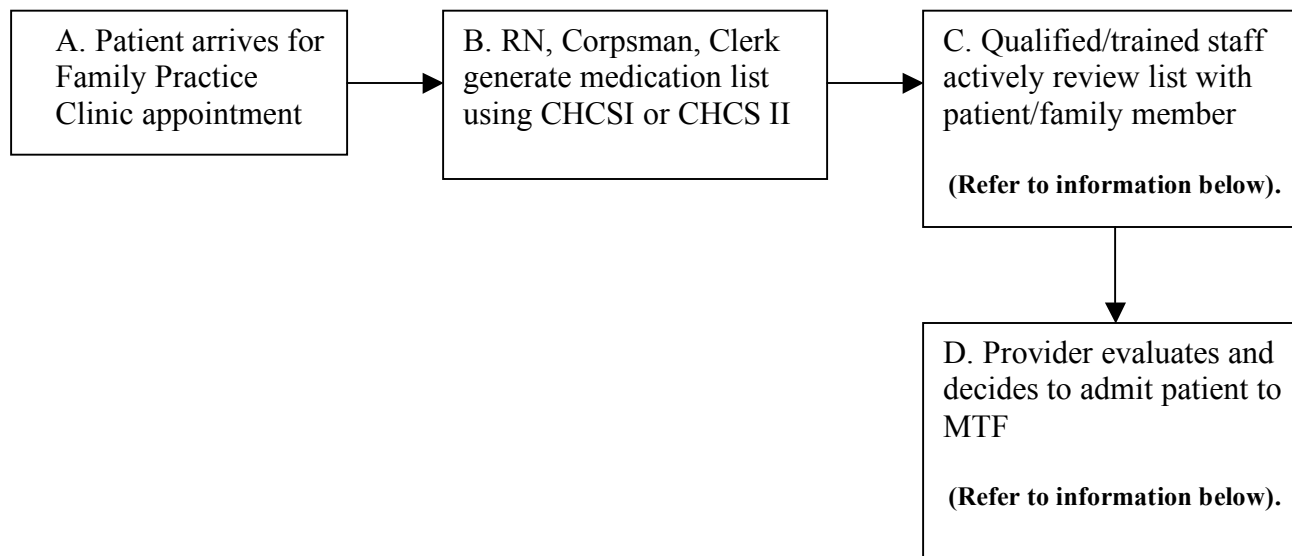
## Scenario 1: Ambulatory Care Patient Visit Only



### Scenario 1: Ambulatory Care Patient Visit Only

- A. Patient arrives for Family Practice Clinic appointment
- B. RN, Corpsman, Clerk generate medication list using CHCSI, CHCS II or SF508 Medication Reconciliation Menu.
- C. Qualified/trained staff actively review list with patient/family member
  - i. Ask the patient/family member what prescription medications they take at home and highlight those medications that correspond on the electronic medication list. Add any other prescription medications not currently on the list.
  - ii. Ask the patient/family member if they are on any sample medications, herbal remedies, vitamins, nutraceuticals, over the counter drugs, vaccines, etc.
  - iii. If patient is not able to answer, ask or phone a family member or significant other
  - iv. Document reconciliation action at the bottom of the electronic list by writing: Medication list reviewed with patient/family member/SO. Sign, time and date it.
  - v. Place medication list with SF 600 into medical record for provider appointment.
- D. Provider evaluates and treats patient
  - i. Prior to completing appointment, provider reconciles medication list with patient / family member. Provider documents:
    1. "C" next to medications they plan to continue
    2. "D" next to medications they plan to discontinue
    3. Writes in new medications he is placing patient on
    4. Documents on bottom of list that medication reconciliation completed; signs, times and dates signature.
    5. Retains list in medical record
- E. Patient education provided by provider, nurse or corpsman
  - i. Patient/family instructed on medications and benefit of maintaining a current medication list (i.e., could use Medication List card\*)
  - ii. Recommend that they bring this list with them to all appointments.
  - iii. Staff documents on SF 600 that this was completed.
- F. Patient discharged home.

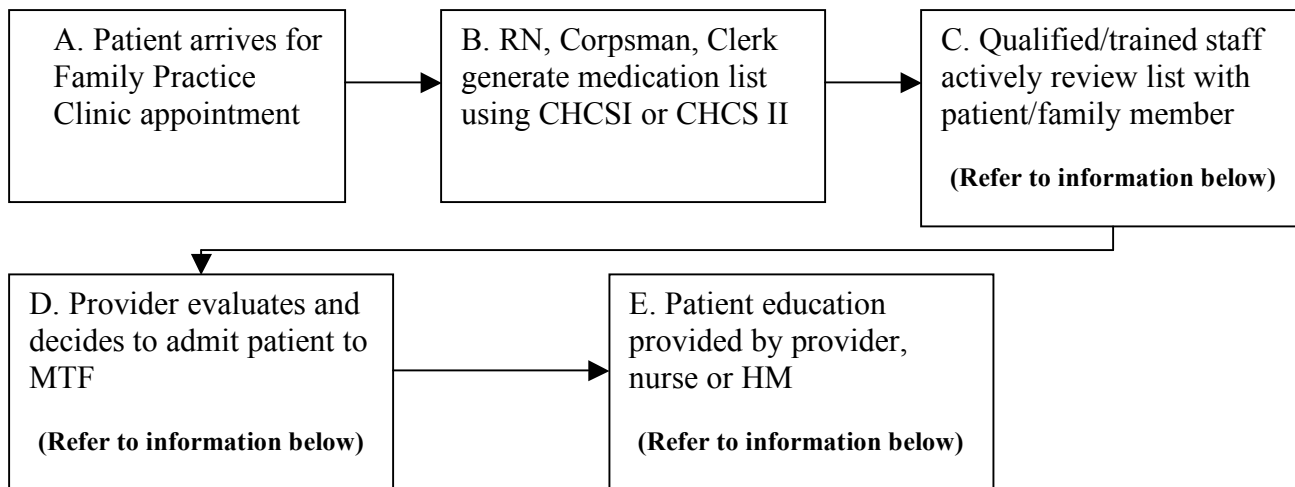
## Scenario 2: Ambulatory Care Patient Admitted to MTF



### Scenario 2: Ambulatory Care Patient Admitted to MTF

- A. Patient arrives for Family Practice Clinic appointment
- B. RN, Corpsman, Clerk generate medication list using CHCSI, CHCS II or SF508 Medication Reconciliation Menu
- C. Qualified/trained staff actively review list with patient/family member
  - i. Ask the patient/family member what prescription medication(s) they take at home and highlight those medications that correspond on the electronic medication list. Add any other prescription medications not currently on the list.
  - ii. Ask the patient/family member if they are on any sample medications, herbal remedies, vitamins, nutraceuticals, over the counter drugs, vaccines, etc.
  - iii. If patient is not able to answer, ask or phone a family member or significant other
  - iv. Document reconciliation action at the bottom of the electronic list by writing: Medication list reviewed with patient/family member/SO. Sign, time and date it.
  - v. Place medication list with SF 600 into medical record for provider appointment.
- D. Provider evaluates and decides to admit patient to MTF
  - i. There are two options for medication reconciliation:
    1. Reconcile medications using printed electronic list actively with patient prior to admitting. Reconciliation should be a comparison of medications patient currently is on to the admitting orders.
    2. Delay medication reconciliation till patient admitted to unit/ward for urgent situations where delay to unit/ward may harm patient
      - a. Perform medication reconciliation on unit/ward as soon as possible (time defined by MTF: i.e. when patient is stabilized, or within 24 hours)
  - ii. Provider documents on the medication list:
    1. "C" next to medications they plan to continues
    2. "D" next to medications they plan to discontinue
    3. Writes in new medications he is ordering for patient
    4. Documents on bottom of list that medication reconciliation Completed, sign, time and date signature.
    5. Retains list with inpatient medical record
    6. Documents on bottom of list that medication reconciliation Completed, sign, time and date signature.
    7. Retains list with inpatient medical record

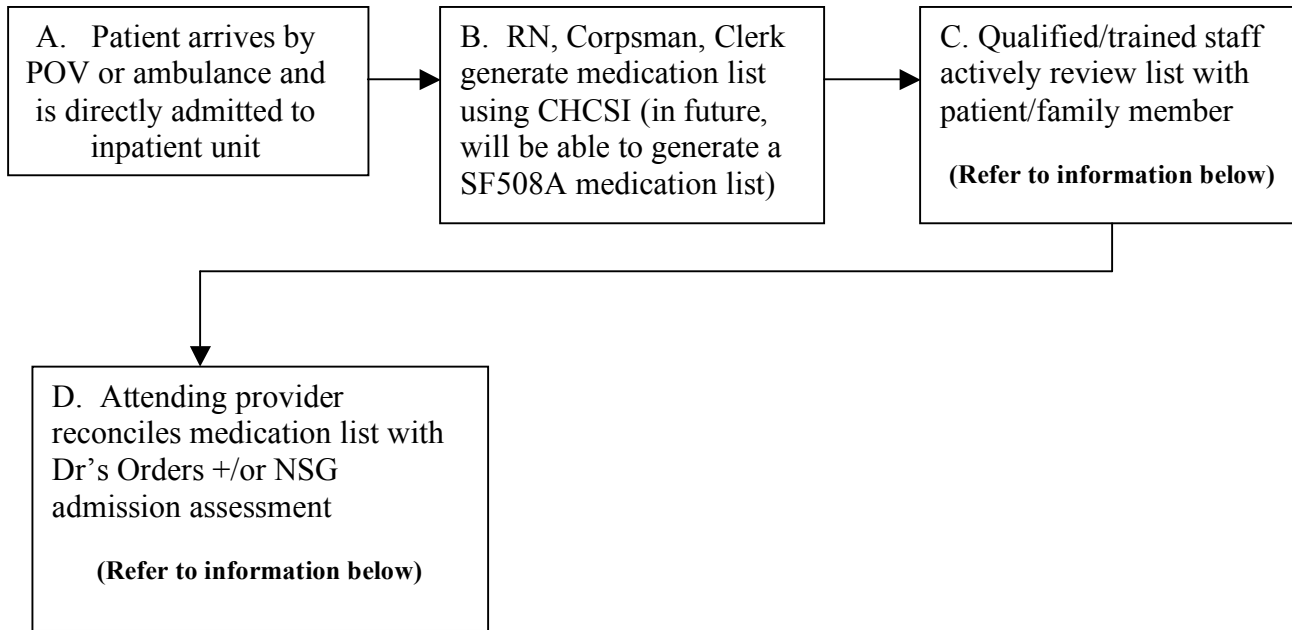
### Scenario 3: Ambulatory Care Patient Consulted to Outside Consultant/Provider



### Scenario 3: Ambulatory Care Patient Consulted to Outside Consultant/Provider

- A. Patient arrives for Family Practice Clinic Appointment
- B. RN, Corpsman, Clerk generate medication list using CHCSI, CHCS II or SF 508 Medication Reconciliation Menu
- C.. Qualified/trained staff actively review list with patient/family member
  - i. Ask the patient what medications they take at home and highlight those medications that correspond on the electronic medication list.
  - ii. Ask the patient if they are on any sample medications, herbal remedies, vitamins, nutraceuticals, over the counter drugs, vaccines, etc.
  - iii. If patient is not able to answer, ask or phone a family member or significant other
  - iv. Document this action at the bottom of the electronic list by writing: medication list reviewed with patient/family member/SO and sign, time and date it.
  - v. Place medication list with SF 600 into medical record for provider appointment.
- D. Provider evaluates and treats patient
  - a. Prior to completing appointment, provider reconciles medication list with patient / family member.
    - i. Reconciliation is the process of comparing what medications the patient is currently taking (using preprinted highlighted medication list) to what the provider plan to prescribe.
      - 1. Purpose is to avoid errors of transcription, omission, duplication of therapy, drug-drug and drug-disease interactions, etc.
    - ii. Provider documents:
      - 1. "C" next to medications they plan to continues
      - 2. "D" next to medications they plan to discontinue
      - 3. Writes in new medications he is ordering for patient
      - 4. Documents on bottom of list that medication reconciliation completed and signs, times and dates signature.
      - 5. Retains list in medical record
- E. Patient education provided by provider, nurse or corpsman
  - i. Patient/family member is given a copy of the reconciled medication list
    - 1. Patient/family is instructed to bring this list with him to share at his consultant appointment in town.
    - 2. Patient/family instructed to bring list (details) of any medications added or changed by outside provider.
  - ii. Patient/family instructed on medications and benefit of maintaining a current medication list (i.e., could use Medication List card\*)
  - iii. Staff recommends that they bring this list with them to all appointments.
  - iv. Staff documents on SF 600 that patient education regarding medication list was completed.

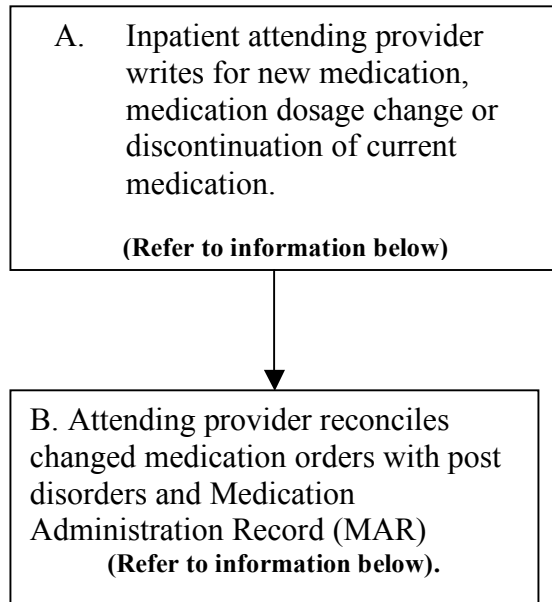
## Scenario 4: Direct Admission to the MTF



### Scenario 4: Direct Admission to the MTF

- A. Patient arrives by POV or ambulance and is directly admitted to inpatient unit
- B. RN, Corpsman, Clerk generate medication list using CHCSI or SF508 Medication Reconciliation Menu.
  - i. Ideal time to do this is when nursing intake assessment is completed
- C. Qualified/trained staff actively review list with patient/family member
  - i. Ask the patient/family member what prescription medication(s) they take at home and highlight those medications that correspond on the electronic medication list. Add any other prescription medications not currently on the list. Verify and document when home medication prescriptions last filled/re-filled.
  - ii. Ask the patient/family member if they are on any sample medications, herbal remedies, vitamins, nutraceuticals, over the counter drugs, vaccines, etc.
  - iii. If patient is not able to answer, ask or phone a family member or significant other
  - iv. Document reconciliation action at the bottom of the electronic list by writing: Medication list reviewed with patient/family member. Sign, time and date it.
  - v. Place medication list with inpatient medical record.
- D. Attending provider reconciles medication list with patient/family and "Dr's Orders" form (SF 508)
  - vi. Provider documents:
    - 1. "C" next to medications they plan to continue
    - 2. "D" next to medications they plan to discontinue
    - 3. Writes in new medications he is ordering for patient
    - 4. Documents on bottom of list that medication reconciliation completed: signs, times and dates signature.
    - 5. Retains list in inpatient medical record

## Scenario 5: Inpatient (MTF) Medication Change (New medication added or Medication discontinued)

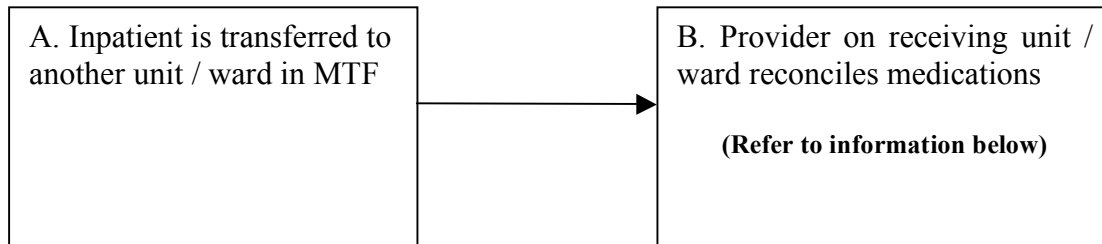


### Scenario 5: Inpatient (MTF) Medication Change (new medication added or medication discontinued)

Reconciliation should occur any time medications are added, changed or discontinued while patient is in inpatient status, goes to OR, returns from OR, or other major procedure.

- G. Inpatient attending provider writes for new medication, medication dosage change or discontinuation of current medication.
  - i. Provider reconciles or compares medications patient is currently taking, using MAR and past “Dr’s Orders”, with new Dr’s Orders.
    - 1. Documents in progress note that medication reconciliation completed with signature, time, date

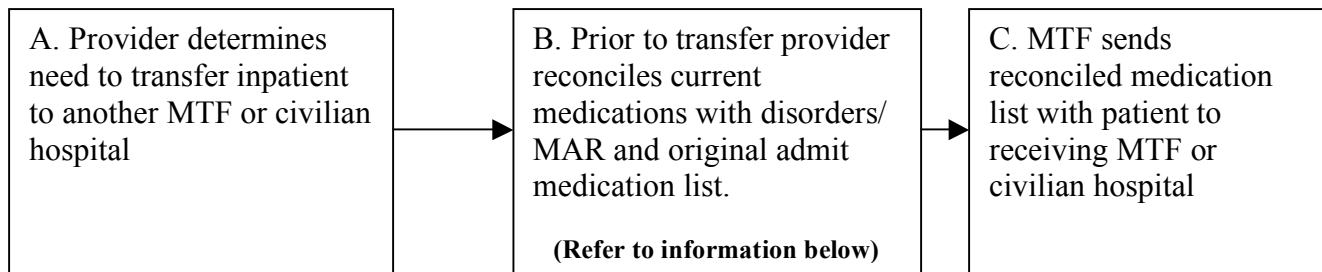
## Scenario 6: Inpatient (MTF) Transfer to another Unit/Ward within the MTF



### Scenario 6: Inpatient (MTF) Transfer to another Unit/Ward within the MTF

- A. Inpatient is transferred to another unit / ward in MTF
- B. Provider on receiving unit / ward reconciles medications.
  - ii. Compares/reconciles the Transfer Dr's Orders with Medication Administration Record and initial admission medication list utilizing CHCSI or SF508 Medication Reconciliation Menu to generate medication list
    - 1. Involves patient/family member in discussion if possible
  - iii. Documents in progress notes that unit transfer medication reconciliation completed with signature, time and date.

## Scenario 7: Inpatient (MTF) Transfer to another MTF or Civilian Hospital



### B. Scenario7: Inpatient (MTF) Transfer to another MTF or Civilian Hospital

- A. Provider determines need to transfer inpatient to another MTF or civilian hospital.
- B. Prior to transfer:
  - i. Provider will reconcile current medication orders with MAR and Admission medication list
  - ii. Documents in progress notes that inpatient transfer medication reconciliation completed with signature, time and date.
- C. Reconciled medication list should accompany patient to next MTF/Hospital

## Scenario 8: Inpatient Discharged to Home

A. Plan to discharge inpatient to home. Prior to discharge.

**(Refer to information below)**

### Scenario 8: Inpatient Discharged to Home

- A. Plan to discharge inpatient to home. Prior to discharge:
  - i. Provider reconciles medications patient was on at home prior to admission, and while an inpatient, with discharge medication orders/plan.
    - 1. Reconcile using CHCSI, CHCSII original medication list or SF508 Medication Reconciliation Menu, Dr's Orders, MAR and Discharge Orders. Re-verify the date(s), obtained at admission, of when home medications were filled/refilled. – Prevent redundant prescriptions.
    - 2. Go over final list with patient / family member
    - 3. Document reconciliation in Progress Notes with signature, time, date
  - ii. RN or provider conducts discharge education with patient/family member
  - iii. Patient/family instructed on medications and benefit of maintaining a current medication list (i.e., could use Medication List card\*)
    - 1. Provide list to patient and place one in Medical Record

## SITUATION BASED RECOMMENDED CHCS I MENU OPTIONS TO GENERATE MEDICATION LISTS

SCENARIO	CHCSI MENU OPTION	RESPONSIBLE STAFF/Actions	COMMENTS
1. Ambulatory Care patient visit only	For automatic printing of medication list on SF600 “CLC” Clinic Customization for SF600	All staff should have access to this key. Active interview with patient going over Med List & any other medications patient may be on.	Generates a SF 600 with an active medication list pulled from local host CHCS and prints automatically on the SF 600
	To manually print a med list during an ambulatory visit  PRI: Prescription Inquiry. This is a pharmacy menu key that can be assigned to staff as a secondary menu key as appropriate  DPRX: At the action prompt in ORE. Gives the complete PDTS profile  DPHR: Gives local host information only.		
2. Ambulatory Care patient who is admitted to the MTF	“PRI” and option “P”  or  “DPRX”	All staff that can access “ORE” should be able to access these menu options.  Reconciliation should occur at point of entry and upon admission.	“PRI”: combined profile of all active & inactive medications (PDTS) up to 180 days ago.  “DPRX”: combined profile of all active and inactive medications (PDTS). Only provides medication & Date, no dosage. Need to do Inquiry to expand & get dosage.
3. Ambulatory Care patient referred to outside specialty consultant	“PRI” or “DPRX”	As above Do Reconciliation & provide list to patient with instructions to bring list with consult to consult appt. Document on SF600 that reconciliation occurred and list provided to pt.	As above. Recommend
4. In-patient (MTF) Transfer to another unit.	“DPOL” or  “DPHR”	As above  Reconcile doing comparison with med list and Medication Administration Record (MAR)	“DPOL” provides profile/ list of active and inactive medications as well as other non-medication orders like RAD and LAB.  “DPHR” provides Active In House Medication List
5. Inpatient to Discharge or Transfer to another Hospital	Use both “DPHR” and “DPRX”	As above Reconcile using both lists and Medication Administration Record (MAR)	“DPHR” provides active inpatient med list and “DPRX” provides active & inactive medication list (note: need to do inquiry to determine dosage)